WITHIN CORPORATE LIMITS

Dr. Hodges

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08600

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 127 Humbird Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mr. Luther Bean

3. (b) Social Security Number: 219-03-8735

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nora Whetzel
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): December 29 1871

8. AGE: Years	Months	Days	If less than one day
73	9	1	...hrs. ...min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Unable to work
11. Industry or business

FATHER
12. Name: Asa Bean
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Sarah Swisher
15. Birthplace: W. Va.

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 4 1945 (month) (day) (year)
Cemetery or crematory Narrowback Cem
Location Springfield Md.
18. Funeral director Edwin Stein Inc
Address Cumberland Md

19. Oct 2 1945 Winter R. Staub M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30, 1945 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Sept. 27 1945 to Sept. 30 1945 and that I last saw h.i.m. alive on Sept. 30 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to Chronic Myocarditis	
Due to Mural thrombi.	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Arteriosclerosis Coronary thrombosis Hemiplegia
Date of op. 9/24/45.
Autopsy results: Above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W.R. Hodges M.D.
Address: Cumberland, Md M. D. or other
Date signed 9/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

Dr. M.E.E. Owens

CHANGE OF AGE: Letter from Dr. Owens, filmed G98 10-16-45 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08601

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 326 Grand Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mr. George L. Beisser

3.(b) Social Security Number: 705-05-4545

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Ayers

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): June 15 1878 1879

8. AGE: Years	Months	Days	If less than one day
64 66	3	7	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Baltimore & Ohio Railroad

FATHER
12. Name: George Beisser
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Pflum
15. Birthplace: Germany

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/25/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept 24 1945 (Date rec'd by registrar) Walter R. Grant, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22, 1945, at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1945, to Sept 22 1945, and that I last saw h alive on Sept 22 1945.

	DURATION
Immediate cause of death: Coma.	4 days
Due to: Chronic interstitial nephritis	several years
Due to: Hypostatic pneumonia, bilateral	4 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M E Owens M.D.

M. D. or other

Address: 133 Va Date signed Sept 22 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

08602

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs

Hospital, Institution, or street address where death occurred: Allegany County Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 218 Oak St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Julia "Hartley" Boden

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph D. Boden

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov 24 1868

8. AGE:

Years	Months	Days	If less than one day
76	9	13	..... hrs. ..... min.

9. Birthplace: Oldtown Allegany Co, Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home

FATHER

12. Name: Conway Hartley

13. Birthplace: Oldtown Md

MOTHER

14. Maiden name: Lavinia Twigg

15. Birthplace: Oldtown, Md.

16. Informant: Mrs Charity Rackley

Address: 136 Va. Ave - Cumb, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10, 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Sept. 10 1945 (Date rec'd by registrar) Winter R. Mantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7, 1945 at 7:40 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 45 1945, to Sept 7 45

and that I last saw h.. alive on Sept 4 1945

Immediate cause of death	DURATION
Infirmities of age	
Due to	
Due to Coronary Occlusion	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 9-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08603

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs - 10 mos - 1 da

Hospital, Institution, or street address where death occurred: No 1 Jackson Street

How long in hospital or institution? c

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1 Jackson Street (If rural, give LOCATION)

2.(a) If veteran, name war: c

3.(a) FULL NAME: Mrs Agnes Pollock Boyd

3.(b) Social Security Number: c

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Alexander Boyd.

6.(c) If alive, give age: c years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1875

8. AGE: Years	Months	Days	If less than one day
69	10	1	..... hrs. ..... min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER — 12. Name: Robert Pollock

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Janet Laird

MOTHER — 15. Birthplace: Unknown

16. Informant: Mrs. Joseph Decker

Address: Williamstown, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 13 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Sept 14 1945 (Date rec'd by registrar) Dr B. Don Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13, 1945 at 1.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Coronary occlusion — DURATION

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op.: .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other

Address: Lonaconing, Md. Date signed: Sept. 14 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-a)

CERTIFICATE OF DEATH

★ 18604 Reg. Dist. No. 8

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76 years
Hospital, institution, or street address where death occurred: Railroad Street
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing (If outside city or town limits, write RURAL and give nearest town)
Street No. Railroad Street (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME John Hamilton Boyd

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma Buckell Boyd B.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Sept 17, 1865

8. AGE:

Years	Months	Days	If less than one day
80	0	9	..... hrs. ..... min.

9. Birthplace Lanarkshire Scotland (Town, county, and state)
10. Usual occupation Coal Miner - Retired
11. Industry or business Georges Creek Coal Co.
FATHER 12. Name George Boyd
FATHER 13. Birthplace Scotland
MOTHER 14. Maiden name Isabel Hamilton
MOTHER 15. Birthplace Scotland
16. Informant Mrs Emma Boyd
Address Lonaconing, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 1945 (month) (day) (year)
Cemetery or crematory Old Coney Cemetery
Location Lonaconing Md.
18. Funeral director Mr Eichhorn
Address Lonaconing
19. Sept 27 1945 (Date rec'd by registrar) D. E. Donaldson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26, 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1945 to ..... 19.....
and that I last saw h— alive on Sept 26 1945

Immediate cause of death Coronary Occlusion — DURATION

Due to ..... —

Due to ..... —

Other conditions ..... —

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. E. Donaldson M. D. or other
Address Lonaconing Date signed 9/27/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-21)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 08605 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Corriganville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Walter Clyde Bridges

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 22, 1945

8. AGE: Years	Months	Days	If less than one day
	3	29	..... hrs. ..... min.

9. Birthplace: Corriganville, Allegany Co, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Walter C. Bridges
13. Birthplace: Chaneyville, Pa

MOTHER
14. Maiden name: Nellie Burkett
15. Birthplace: Mt. Savage, Md.

16. Informant: Mrs. Walter C. Bridges
Address: Corriganville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/23/45 (month) (day) (year)

Cemetery or crematory: Porter Cemetery

Location: Hyndman, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 22, 1945 (Date rec'd by registrar) Witter R. Brantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 19 45 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/20 19 45, to 9/21 19 45 and that I last saw h... alive on 9/20 19 45

Immediate cause of death: enterocolitis — DURATION: 2

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Elizabeth Bruce M.D.
M. D. or other

Address: Lonaconing, Md. Date signed 9/22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

68606

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 506 Woodside Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nora Burch

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Elbert O Burch

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 28 1877

8. AGE: Years 67 | Months 11 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Henry C Hosal

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Alice M Bell

MOTHER — 15. Birthplace: Cumberland Md

16. Informant: Mrs Geo R. Gormer

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22 '45 (month) (day) (year)

Cemetery or crematory: St Lukes Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Sept 22 1945 (Date rec'd by registrar) Wintes R. Crantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1945, to Sept. 20 1945, and that I last saw her alive on Sept. 19 1945

Immediate cause of death	DURATION
Cardio Vascular Renal Disease	2 yrs
Due to: Hypertension	7 yrs
Due to: Uraemia	6 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Clark S. Furrey M. D. or other

Address: Cumberland Date signed 9/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

08607

Reg. Dist. No. 4

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years 6

Hospital, Institution, or street address where death occurred: Allegany Co. Infirmary

How long in hospital or institution? 15 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City: Near Cumberland, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No.: Routel, LaVale (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Minnie "Carl" Carter

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Lucius B. Carter

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Sept 7, 1879

8. AGE:	Years	Months	Days	If less than one day
	66	0	18	...hrs. ...min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: August Carl

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: ? "

MOTHER 15. Birthplace: "

16. Informant: Lucius B. Carter

Address: Routel, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Sept. 27, 1945 (Date rec'd by registrar) Wynter P. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25 19 45, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1944, to Sept. 25 1945 11:30 A.M. and that I last saw h... alive on Sept. 24 1945 9:45 A.M.

	DURATION
Immediate cause of death: Chronic Myocarditis	Unknown
Due to: Degeneration of	?
Due to: Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 9-27-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

08608

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 yrs

Hospital, institution, or street address where death occurred: 7 N Pershing St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7 N Pershing St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Pedoit Conway

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Etta F. Conway

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 24, 1875

8. AGE: Years	Months	Days	If less than one day
70	6	2	hrs. min.

9. Birthplace Confluence, Penna.
(Town, county, and state)

10. Usual occupation Locomotive Engineer, Retired

11. Industry or business R. R. Co.

FATHER 12. Name James A. Conway

FATHER 13. Birthplace Martinsburg, W. Va.

MOTHER 14. Maiden name L. Wyant

MOTHER 15. Birthplace Penna.

16. Informant James A. Conway

Address 7 N Pershing St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 29, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

16. Funeral director John C. Walford

Address Cumberland, Md.

19. Sept 29 19 45 (Date rec'd by registrar) Hunter R. Craig, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9. 26. 1945 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5. 13. 1945, to 9. 26. 1945 and that I last saw him alive on 9. 23. 1945

	DURATION
Immediate cause of death Chronic Myocardial Degeneration	
Due to Essential Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 9-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

3446

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore (61)

CERTIFICATE OF DEATH

08609

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28

Hospital, institution, or street address where death occurred:
436 Pine Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 436 Pine Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Hannah Matilda Cooper

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Colored Negro	Married

6.(b) Name of husband or wife: Harry C Cooper

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Feb 29, 1889

8. AGE:

Years	Months	Days	If less than one day
56	6	8	...hrs. ...min.

9. Birthplace: Capon Bridge W Va
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: At Home

FATHER
12. Name: Boyd Hamilton
13. Birthplace: Capon Bridge W Va.

MOTHER
14. Maiden name: Fannie Washington
15. Birthplace: Capon Bridge, W Va.

16. Informant: H C Cooper
Address: 436 Pine Ave Cumberland, Md

17. Burial
(Burial, cremation, or removal. Where?)
Date thereof: Sept 10 1945
(month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland, Md

18. Funeral director: Thos. A. Knight

Address: Cumberland Md

19. Sept. 10, 1945 Walter R. Brantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8, 1945 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1945 to Sept 8 1945 and that I last saw h... alive on Sept 7 1945

Immediate cause of death	DURATION
Diabetic Coma	24 hours
Due to: Diabetis	3 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Thos A Knight M. D. or other

Address: Cumberland Md Date signed: 4-5-3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68610

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 mos
Hospital, Institution, or street address where death occurred:
400 Furnace St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 400 Furnace St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ellen E. Dawson

3.(b) Social Security Number none

4. Sex	5. Color or race	B.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Abraham J. Dawson
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 5 1870

8. AGE: Years	Months	Days	If less than one day
75	6	18	..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John Criswell
13. Birthplace Md.
MOTHER 14. Maiden name Unknown
15. Birthplace
18. Informant Mrs Burke C Brown
Address Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26 '45 (month) (day) (year)
Cemetery or crematory Rose Hill Cem
Location Cumberland
18. Funeral director Louis Stein Sons
Address Cumberland
19. Sept. 20 1945 (Date rec'd by registrar) Hunter R Dantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1945 at 10.45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Death was Sudden 19.. to Brief Dead 19..
and that I last saw h.. alive on Sept 23 19..45
Immediate cause of death Organic Heart Disease, Sudden — DURATION: Several Years
Due to Organic Heart Disease — DURATION: 2 or 3 yrs.
Due to Chronic Nephritis — DURATION: 2 yrs
Other conditions — DURATION:
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results None made
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Thos H Dawson M.D.
M. D. or other
Address Cumberland Md Date signed 9/24/45

WITHIN CORPORATE LIMITS

68611

Dr. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Sylvan Retreat
How long in hospital or institution? 40 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: McCoole
(If ontside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Isaac Dayton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ida Brewer Dayton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1867

8. AGE:	Years	Months	Days	If less than one day
	77	9	23	hrs. min.

9. Birthplace: Mineral County, W.Va.
(Town, county, and state)
10. Usual occupation: Car repairman (Retired)
11. Industry or business: B. & O. Ry. Co.

FATHER
12. Name: Isiah Dayton
13. Birthplace: W.Va.

MOTHER
14. Maiden name: Rebecca Feathers
15. Birthplace: W.Va.

16. Informant: L. I. Dayton
Address: McCoole, Md. (P.O. Keyser, W.Va.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27, 1945 (month) (day) (year)
Cemetery or ~~crematory~~: Dayton Cemetery
Location: near 21st Bridge, Md.

18. Funeral director: B.W. Markwood
Address: Keyser, W.Va.

19. Sept 25, 1945 (Date rec'd by registrar) Walter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25, 1945, at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-14-45 to 9-25-45 and that I last saw h[im] alive on 9-22-45

	DURATION
Immediate cause of death: Extremities of age	
Due to: Generalized Arteriosclerosis?	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W.F. Williams M. D. or other
Address: Cumberland Date signed: 9-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08612

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157b

★ Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Mos. 13 Days.

Hospital, institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution? 5 Mos. 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Mines, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route No. 1 Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edwards Richard Delaney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 13 - 1945

8. AGE: Years | Months: 5 | Days: 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace Frostburg Allegany, Md.

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Wm. C. Delaney

13. Birthplace Eckhart, Md.

MOTHER 14. Maiden name Bonnie McKenzie

15. Birthplace Lord, Md.

16. Informant Mr. Wm. C. Delaney

Address Route No 1 Frostburg Md

17. Burial Date thereof 9-28-1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg, Md.

18. Funeral director Talbot Waters

Address Frostburg, Md.

19. 9-28 1945 Mrs. Nancy N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1945 at 9.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 13 1945 to ..... 19..... and that I last saw him alive on Sept 26 1945

Immediate cause of death	DURATION
Congenital defarmity, Spina Bifida	5 1/2 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.O.M. Lane Jr. M.D.

M.D. Attended

Address Frostburg Md Date signed Sept 27 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS C.L. Dwarts

08614

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
446 Williams St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 446 Williams St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Serena Virginia "Hamilton" Dicken

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Olen Dicken
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 10, 1860

8. AGE: Years	Months	Days	If less than one day
85	2	27	..... hrs. ..... min.

9. Birthplace: Chaneysville, Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: John Hamilton
13. Birthplace: Pa.
MOTHER 14. Maiden name: Sarah O'Neal
15. Birthplace: Chaneysville, Pa.
16. Informant: Daisy M. Collins
Address: 446 Williams St
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9, 1945 (month) (day) (year)
Cemetery or crematory: Chaneysville Methodist Cemetery
Location: Chaneysville, Pa.
18. Funeral director: Ellis J. Hafer
Address: Cumberland, Md.
19. Sept. 9, 1945 Walter R. Klautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7, 1945, at 3:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1945, to Sept 7 1945
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs
Due to	
Due to Hypertension	
Other conditions Senescent	years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Penn Hillcrest Md Date signed: 9-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

(M)

08615

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 yrs.

Hospital, institution, or street address where death occurred:
50 Boone St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany.

City or town: Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 50 Boone St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Russell Dreming.

3.(b) Social Security Number 214-14-7527

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Ethel Parker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 11 1898

8. AGE: Years: 47 | Months: 5 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Painting

11. Industry or business: Contractor

FATHER — 12. Name: John H. Dreming

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Carrie Hull.

MOTHER — 15. Birthplace: Md.

16. Informant: John W. Dreming

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Son

Address: Cumberland

19. Sept. 11, 19 45 (Date rec'd by registrar) Winter R. Frank, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8, 19 45, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 19 to Sept 8 19 45; and that I last saw h... alive on Sept 8 19 45.

Immediate cause of death	DURATION
(a) Coronary Thrombosis	
Due to (b) Myocarditis	Chr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. H. Ellenger M. D., or other

Address: ..... Date signed: 9/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08613

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 78 yrs.
Hospital, institution, or street address where death occurred: Stoney Run Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Westernport, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Stony Run Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Canby Shaffer Duckworth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Thursey Duckworth
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Dec. 21, 1866

8. AGE:	Years	Months	Days	If less than one day
	78	9	2	...hrs. ...min.

9. Birthplace: Westernport-Allegany-Md. (Town, county, and state)
10. Usual occupation: Wood-Cutter
11. Industry or business: Plup wood.

FATHER
12. Name: Thornton Duckworth
13. Birthplace: Virginia

MOTHER
14. Maiden name: Olive Miller
15. Birthplace: Westernport, Md.

16. Informant: Mrs. Canby Duckworth
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept. 26, 45 (month) (day) (year)
Cemetery or crematory: Philos Cemetery
Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal.
Address: Westernport, Md.

19. Sept. 26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 23 19 45, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... to ... 19 45 and that last saw h... alive on ... 19

Immediate cause of death: ... DURATION

Due to: ... 7 yrs

Primary cancer of the stomach;

Due to: with metastases, cyst K.

Other conditions: ... 9 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: ... M. D. or other
Address: ... Date signed 9/26/45

68616

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred: Miners hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Leo Eagan

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9, 1945

8. AGE: Years	Months	Days	If less than one day
		8	hrs. min.

9. Birthplace Frostburg, Allegany, Md.
(Town, county, and State)

10. Usual occupation

11. Industry or business

FATHER
12. Name Edward B. Eagan
13. Birthplace Midland Md.

MOTHER
14. Maiden name Hilda Smith
15. Birthplace Frostburg Md.

16. Informant Eugene Eagan
Address Midland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18, 1945 (month) (day) (year)

Cemetery or crematory St. Josephs Cemetery

Location Midland Md

18. Funeral director J. J. Duerst

Address Frostburg Md.

19. 9-18 (Date rec'd by registrar) 19 45 Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 19 45, at 5 35 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9/9 19 45 to 9/17 19 45 and that I last saw h... alive on 9/17 19 45

Immediate cause of death: Congenital heart — DURATION

Due to:

Due to:

Other conditions: 6 fingers on each hand

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE Hilda Smith Walters M.D. or other

Address Frostburg Date signed 9/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Walters 086179

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Bowery St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Engle

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nellie C. Engle

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): January 15, 1864

8. AGE: Years: 81 | Months: 8 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Morantown Allegany Cty. Md
(Town, county, and state)

10. Usual occupation: Farmer (retired)

11. Industry or business

FATHER
12. Name: John Engle
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Bittner
15. Birthplace: Germany

16. Informant: Mrs. James McNeil, Jr.
Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 23 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Dust

Address: Frostburg Md.

19. 9-22 1945 Mrs Nadey H. Rae
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 1945, at 2.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1945 to Sept 20 1945 and that I last saw h. alive on Sept 26 1945

Immediate cause of death	DURATION
Cerebral Concussion	24 hrs
Due to fall down steps	
Due to	
Other conditions Fracture rt rib	
Fracture rt rib	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 9/19/45
Where did injury occur? Frostburg (City or town) Allegany (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Fell down steps Injured at work?

23. SIGNATURE: Hilda Purkeypile Walters M.D.
M. D. or other

Address: Frostburg Date signed: 9/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Outside of City Limits

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 08618

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Near Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 Yrs.
Hospital, institution, or street address where death occurred:
R.D.#3. Bedford Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D.#3 Bedford Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mellie Mae Ensminger

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William I. Ensminger
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 23, 1886

8. AGE: Years	Months	Days	If less than one day
59	2	17	..... hrs. ..... min.

9. Birthplace: Williamsport, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Samuel W. Lindsay
13. Birthplace: Maryland

MOTHER
14. Maiden name: Fannie Goodrich
15. Birthplace: Maryland

16. Informant: Mr. William I. Ensminger
Address: R.D.#3 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland.
18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Sept. 11, 1945 (Date rec'd by registrar) Miles L. Hantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10, 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 10 1945 to Sept 10 1945
and that I last saw h[illegible] alive on Sept 10 1945

Immediate cause of death	DURATION
Coronary occlusion	2 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. T. Trevaskis M.D. M. D. or other
Address: Cumberland, Md Date signed: Sept 10 - '45

WITHIN CORPORATE LIMITS

Dr. Mathews

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

C8621 4

Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 3 Dys.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 318 Avirette Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Daniel Joseph Flynn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Elizabeth E. Adams
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Mar. 7, 1896

8. AGE: Years	Months	Days	If less than one day
49	6	21	...hrs. ...min.

8. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: Cook
11. Indusfry or business: Fraternal Order Of Eagles
FATHER 12. Name: Michael Flynn
13. Birthplace: Ireland
MOTHER 14. Malden name: Johanna Bahn
15. Birthplace: Ireland
16. Informant: Mrs. Elizabeth Flynn
Address: 318 Avirett Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 1, 1945 (month) (day) (year)
Cemetery or crematory: St. Patricks Cem.
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Sept. 30, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28, 1945, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1945 to Sept 28 1945 and that I last saw h... alive on sept 28 1945

Immediate cause of death	DURATION
Chronic nephritis	
Due to	
Due to	
Other conditions: Hypertension, Myocardiale	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. B. Mathews M. D. M. D. or other
Address: 49 Greene St Date signed: 9-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. LOUIS OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

08619

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 15 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro tofaots give resideoce of mother)
State WEST VIRGINIA County MINERAL
City or town KEYSER
(If outside city or towo limits, write RURAL and give nearest town)
Street No. 190 CENTRE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. MAUDE P. FRYE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife RICHARD FRYE
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) JULY 12, 1886

8. AGE:	Years	Months	Days	If less than one day
	59	2	C	....hrs. ....min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business
FATHER 12. Name WILLIAM C. PARKER
FATHER 13. Birthplace WEST VIRGINIA
MOTHER 14. Maiden name FANNIE MITINGER
MOTHER 15. Birthplace WEST VIRGINIA
16. Informant MEMORIAL HSOPITAL
Address CUMBERLAND, MD.
17. Burial (Borial, cremation, or removal. Which?) Date thereof Sept 14, 1945 (month) (day) (year)
Cemetery or crematory Indian Mound Cem.
Locatioo Romney, W.Va.
18. Funeral director J. H. Markwood Sons.
Address Keyser, W.Va.
19. Sept 12 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 12 19 45 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 45 to Sept 11 19 45 and that I last saw her alive on Sept 11 19 45

Immediate cause of death	DURATION
Due to General Carcinomatosis	
Due to Carcinoma of Breast operation 5 yrs ago	2 yrs
Other conditions Anaemia	

(Include pregnancy withio 3 months of death)

Major findings of operatioos
Date of op.
Autopsy results
PHYSICIAN: Please uoderline the canse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (Coonty) (State)
Injured at home, farm, lodustry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D. M. D. or other
Address Cumberland Date signed 7-11-45

WITHIN CORPORATE LIMITS

08620

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred: 616 S Fruser Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 616 S Fruser Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Martha Gelhausen

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Chas Gelhausen

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 77 | Months: | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: Hellertown Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Geo Wilhelm

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Mary Martin

15. Birthplace: Pa.

16. Informant: Mrs. Hersey Shinck

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland

18. Funeral director: Lewis Stein Inc

Address: Cumberland

19. Sept. 24 1945 (Date rec'd by registrar) Walter L. Beantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 1945 at 7.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to Sept 1945, and that I last saw h... alive on Sept 4 1945.

	DURATION
Immediate cause of death: Myocardial Heart Disease	a year
Due to:	
Due to: Primary carcinoma of intestines C.U.S.P.	
Other conditions: Ulcers in stomach and pyelitis cause of death	years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. Alan G. Beaumont M.D.
M. D. or other

Address: Cumberland Md. Date signed: 9/24/45

08622

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Allegany

City or town: Rural near Rawlings
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural - Rawlings
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R # 3
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Bessie Gordon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Ulysis G. Gordon

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 23, 1872

8. AGE: Years	Months	Days	If less than one day
73	2	22	..... hrs. ..... min.

9. Birthplace: Old Town, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Michael Braftree

13. Birthplace: Old Town, Md.

MOTHER — 14. Maiden name: Edna Twigg

15. Birthplace: Old Town, Md.

16. Informant: Mrs. Cora V. Dawson

Address: Rawlings, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-17-46 (month) (day) (year)

Cemetery or crematory: Bierstown Cemetary

Location: Rawlings, Md.

18. Funeral director: N.E. Rogers Funeral Director

Address: Keyser, W. Va.

19. Sept. 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15, 1945, at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to March 17, 1945, and that I last saw h.e.r. alive on March 17, 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hrs +
Due to: High blood pressure	15 mos +
Due to: Arteriosclerosis	15 mos +
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. A. Flick, M.D. M. D. or other

Address: Keyser, W Va. Date signed 9-17-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (177)

CERTIFICATE OF DEATH

08623 Reg. Dist. No. 10

1. PLACE OF DEATH:
County: Allegany .
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Calla Hill
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Calla Hill
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Colin Grahame

3.(b) Social Security Number: 214-01-0149

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Grahame
6.(c) If alive, give age: 70 years
7. Birth date of deceased (mo., day, yr.): February 22, 1873

8. AGE: Years	Months	Days	If less than one day
72	5	13	hrs. min.

9. Birthplace: Frostburg, Allegany, Maryland
(Town, county, and state)
10. Usual occupation: retired brick worker
11. Industry or business: brick yard

FATHER
12. Name: Richard Grahame
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bernadine Duke
15. Birthplace: Maryland

16. Informant: Rockwell Grahame.
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 7, 1945 (month) (day) (year)
Cemetery or crematory: St. Patrick's Cemetery.
Location: Mt. Savage, Md.

18. Funeral director: J. J. Durst.
Address: Frostburg, Md.

19 9-6- 1945 (Date rec'd by registrar) Veronica McDermitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4 1945, at 4:25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1945, to Sept 4 1945
and that I last saw him alive on Sept 4 1945

	DURATION
Immediate cause of death: Acute Gastro Enteritis	36 h
Due to: Food Poisoning; Name the food : don't know	48 h
Due to: [illegible]	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [illegible signature] M. D. or other
Address: [illegible] Date signed: 9-5-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08624

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 hrs.

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 22 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany.

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 54 Elder St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Edward William Gross

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 9-14-45

8. AGE: Years | Months | Days | If less than one day: 22 hrs. 4 min.

9. Birthplace: Cumberland Allegany, Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: George Gross

FATHER — 13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Fannie Roby

MOTHER — 15. Birthplace: W. Va.

16. Informant: Mrs. Fannie Gross

Address: 54 Elder St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Sept. 18, 1945 (Date rec'd by registrar) Winter R. Brantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1945 at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1945 to Sept 15 1945 and that I last saw h.. alive on Sept 14 1945.

Immediate cause of death	DURATION
Meningeal Hemorrhage	4 hours
Due to: Fall cliff on road	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Cumberland Md. Date signed: Sept 15 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ 08625 Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45. Years

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 1 Hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 806. Sylvan Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Growley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Growley

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 15 1859

8. AGE: Years 86 | Months 3 | Days 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER 12. Name: George Humbertson

FATHER 13. Birthplace: Lord, Md.

MOTHER 14. Maiden name: Mary Bakeman

MOTHER 15. Birthplace: Humbertson Town, Pa.

16. Informant: Yeagle Humbertson

Address: 806. Sylvan Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 23, 1945 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 28, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21, 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 21, 1945 to Sept. 21, 1945 and that I last saw her alive on Sept. 21, 1945

Immediate cause of death	DURATION
Acute Myocardial Failure (Pulmonary Edema)	4 Hours
Due to: Coronary Artery Disease	?
Due to: Myocardial Disease	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lemuel Humbertson M. D. or other

Address: 15 S. Liberty St. Date signed: 9/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

C8626

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Days

Hospital, institution, or street address where death occurred:
1015 Grape Alley

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 152 Wineow St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Hall

3.(b) Social Security Number: 216-14-1986

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
44			..... hrs. ..... min.

9. Birthplace: Paris, Kentucky
(Town, county, and state)

10. Usual occupation: Maid

11. Industry or business: Southern Hotel

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rebecca Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Bessie Shepard

Address: 1015 Grape Alley, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/13/45 (month) (day) (year)

Cemetery or crematory: Sumner Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 13, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10 19 45, at 10-30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 19 45 to Sept 10 19 45 and that I last saw h... alive on Sept 10 19 45

Immediate cause of death	DURATION
Cirrhosis of Liver	2 yrs
Due to Chronic Alcoholism	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. B. Owens M. D. or other

Address: 133 Va Ave Date signed 9/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

08627

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Thomas Sherman Hite

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

B.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 14, 1940

8. AGE: Years: 5 | Months: 5 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Norfolk Va. (Town, county, and state)

10. Usual occupation: Intfant

11. Industry or business

FATHER
12. Name: Alvin P. Hite
13. Birthplace: Bedford Valley, Pa.

MOTHER
14. Maiden name: Jennie Heywood
15. Birthplace: Norfolk, Va.

16. Informant: J. S. Hite
Address: Manns Choice, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 28, 1945 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Bedford, Pa. (rural)

18. Funeral director: Fred C. Pate & Son
Address: Bedford, Pa.

19. Sept. 26, 1945 Walter R. Beachy M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 1945 at 5 17 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24 1945, to September 25 1945 and that I last saw h[illegible] alive on September 25 1945

Immediate cause of death	DURATION
fractured cranium	9 hours
laceration of the brain	
Due to automobile accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 9-24-45
Where did injury occur? Bedford Road (City or town) Bedford (County) Md. (State)
Injured at home, farm, industry, public place (where?) Bedford Rd
Means of injury hit telegraph pole Injured at work? no

23. SIGNATURE: L Bowers M.D.
M. D. or other
Address: Lonaconing Md. Date signed 9-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

68628

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH ★

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years

Hospital, Institution, or street address where death occurred:
514. Frederick St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 514. Frederick St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Florence Hodges

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: A. H. Hodges

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 4 1874

8. AGE: Years	Months	Days	If less than one day
70	10	16	..... hrs. ..... min.

9. Birthplace: Barton, Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: John Wagner
13. Birthplace: Barton, Md.

MOTHER
14. Maiden name: Elizabeth Mc Robie
15. Birthplace: Swanton, Maryland

16. Informant: Miss Flo Hodges
Address: 514. Frederick St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/23/45 (month) (day) (year)

Cemetery or crematory: Queens Point Cemetery

Location: Keyser, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept 22 1945 (Date rec'd by registrar) Winter R. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 19 45 at 11-50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9. 1. 45 19 45, to 9. 20 19 45 and that I last saw h. alive on 9. 17 19 45

Immediate cause of death		DURATION
	Chronic Nephritis	
Due to	Arterio Hypertension	
Due to	Generalized Arteriosclerosis	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 9-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

DR. HAWKINS

08629

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-h)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County HAMPSHIRE
City or town PURGITTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME MR. ROBERT E. HUFFMAN

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLED

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 27- 1878

8. AGE: Years	Months	Days	If less than one day
67	6	22	...hrs. ...min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation FARMER

11. Industry or business

FATHER 12. Name ELIJAH HUFFMAN
13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name SALLIE TAYLOR
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21 1945 (month) (day) (year)
Cemetery or ~~crematory~~ Old Pine Church
Location Near Purgittsville - W Va

18. Funeral director P. E. Hitchcock & Son
Address Moorefield - W Va

19. Sept 21, 1945 (Date rec'd by registrar) Winter R. Brantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 19, 1945 7:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 7, 1945 to SEPT. 19, 1945 and that I last saw him alive on Sept 18, 1945

Immediate cause of death	DURATION
Ruptured tubal pregnancy	2 hrs
Due to Adherence Explosive	
Due to Explorator incision	
Other conditions Shock	
(Include pregnancy within 3 months of death) No other	

Major findings of operation Ruptured tubal pregnancy
Adherence subsequent

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins M. D.
Address Cumberland Md Date signed 9/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

08630

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:
5 Broadway

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5 Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Jane Kalbaugh

3.(b) Social Security Number: none

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: John F. Kalbaugh

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): aug 11 - 1862

8. AGE:

Years	Months	Days	If less than one day
83	0	22	____ hrs. ____ min.

9. Birthplace: Baton - alleg - md.
(Town, county, and state)

10. Usual occupation: house wife

11. Industry or business:

FATHER
12. Name: Russel Beveridge
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Mary Miller
15. Birthplace: md.

16. Informant: Mrs James Hanna
Address: Frostburg md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4-1945 (month) (day) (year)

Cemetery or ~~crematory~~: allegany

Location: Frostburg

18. Funeral director: J. J. Ahearn

Address: Frostburg

19. 9-4 1945 Mrs. Vaud V. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1945 at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from aug 29 1945, to Sept 2 1945 and that I last saw h.. alive on Sept 1 1945

Immediate cause of death	DURATION
Coronary Thrombosis	8 Days
Due to: Arterio Sclerosis	years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W O'M Lane Jr MD
M. D. or other

Address: Frostburg Md Date signed: Sept 9 1945

Evidence for the change of
WITHIN CORPORATE LIMITS
date of birth is shown on
DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

08631

CERTIFICATE OF DEATH

FILED G98 OCT 29 1945

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County Hampshire
City or town SPRINGFIELD. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME FRANCES LOUISE KESNER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 30, 1945

8. AGE: Years	Months	Days	If less than one day
	3	4	..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name GEORGE W. KESNER
13. Birthplace PETERSBURG, W. VA.

MOTHER
14. Maiden name LENA BOYER
15. Birthplace PETERSBURG, W. VA.

16. Informant Geo W. Kesner
Address Springfield. W. Va.

17. Burial Date thereof 9-6-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Forrest Glen Cemetery
Location Shenandoah Junction. W. Va.

18. Funeral director Thrush's.
Address Romney. W. Va.

19. Sept. 5, 1945 Winter R. Trantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 4, 1945, at @ 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4, 1945, to Sept. 4, 1945
and that I last saw h... alive on Sept. 4, 1945

	DURATION
Immediate cause of death: Hemorrhage	2 Wks
Due to: Malnutrition	2 Wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? NO (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. W. Eliason M.D. M. D. or other
Address Romney W. Cumberland Md Date signed 9/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

08632

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allehany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 yrs
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 31 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 33 Boone Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Ada Kidwell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Joseph Kidwell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 10 1887

8. AGE: Years	Months	Days	If less than one day
58	6	15	..... hrs. ..... min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business at Home.

FATHER
12. Name Lasta Miller
13. Birthplace W. Va.

MOTHER
14. Maiden name Alice Day
15. Birthplace W. Va.

16. Informant Jos. Kidwell
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27 45 (month) (day) (year)
Cemetery or crematory Woodrow Cem
Location Woodrow W. Va.

18. Funeral director Louis Stein Inc
Address Cumberland.

19. Sept 26, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1945, at 7" M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 21 1945, to September 25 1945 and that I last saw h-- alive on September 24 1945

	DURATION
Immediate cause of death cerebral hemorrhage	5 days
Due to arterial hypertension	2
Due to chronic nephritis	2
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. Bruno M D
M. D. or other
Address Long Mdw Date signed 9-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08633

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Flintstone
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, Institution, or street address, where death occurred: Town Creek Rd.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Flintstone R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Town Creek Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Francis Ritchie Kifer

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Alice J. Leasure
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 22 1867

8. AGE: Years	Months	Days	If less than one day
78	2	12	... hrs. ... min.

9. Birthplace: Near Oldtown Md. (Town, county, and state)
10. Usual occupation: Retired Grocer
11. Industry or business: —

FATHER
12. Name: Kifer
13. Birthplace: Md

MOTHER
14. Maiden name: Catherine Kifer
15. Birthplace: Md.

16. Informant: Mrs Vernon R Miller
Address: Flintstone Md R. F. D.

17. Burial, cremation, or removal. Which?: Burial Date thereof: Sept 6 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland.
18. Funeral director: Louis Stein Inc.
Address: Cumberland.

19. (Date rec'd by registrar) Sept 6 1945 Nimal L. Bender, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4th, 1945, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Pierce H. Boyson, M.D.
Address: Cumberland, Maryland
M. D. or other
Date signed: 9-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08634

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 Years

Hospital, Institution, or street address where death occurred:
424 Greene St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 424 Greene St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Martin Francis Kilroy

3.(b) Social Security Number

220-10-4356

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Fannie Kilroy

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): October 16, 1869

8. AGE: Years	Months	Days	If less than one day
75	11	13	..... hrs. ..... min.

9. Birthplace: Piedmont, Mineral Co, West Virginia
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Celenese Corporation

FATHER
12. Name: Thomas Kilroy
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget Rowan
15. Birthplace: Ireland

16. Informant: Mrs. Leona Ford

Address: 424 Greene St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/3/45 (month) (day) (year)

Cemetery or crematory: St Patrick Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct 2 (Date rec'd by registrar) 19 45 Walter R. Trautman M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29th., 1945, at 8.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Prince H. Brown M.D.
M. D. or other

Address: Cumberland, Maryland. Date signed 9-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-8)

CERTIFICATE OF DEATH

08635

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ months
Hospital, Institution, or street address where death occurred:
County Infirmary
How long in hospital or institution? 2½ months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Railroad Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Henry Knapp

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1883.

8. AGE:

Years	Months	Days	If less than one day
62	6	27	... hrs. ... min.

9. Birthplace: Lonaconing, Allegany Co. Md.
(Town, county, and state)
10. Usual occupation: Cabinet Maker & Upholsterer
11. Industry or business: Own Shop
FATHER 12. Name: John Knapp
13. Birthplace: Pennington
MOTHER 14. Maiden name: Josephine Rase
15. Birthplace: Baltimore, Md
16. Informant: Mrs. Josephine Carter
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 24, 1945 (month) (day) (year)
Cemetery or crematory: Sts. Peter & Paul's Cemetery
Location: Cumberland, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. Sept. 24, 1945 (Date rec'd by registrar) Walter R. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-22-1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8, 1945, to Sept. 22, 1945
and that I last saw h[im] alive on 9-19-1945

	DURATION
Immediate cause of death: Carcinoma of Tongue	9
Due to:	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland, Md. Date signed: 9-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

08636

Reg. Dist. No. 4

M

1. PLACE OF DEATH:
County ALLEGANY
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 DAY
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town ~~CORRIDA W.VA.~~ Grantsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. ~~State Rd #50~~
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME
MR JOHN W. LANCASTER

3.(b) Social Security Number
274-05-5241

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife Myrtle S Rhodes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JUNE 8 1901

8. AGE: Years	Months	Days	If less than one day
44	2	27	..... hrs. ..... min.

9. Birthplace MD. (Town, county, and state)
10. Usual occupation TOURIST CAMP OPERATER
11. Industry or business

FATHER
12. Name BENJAMIN LANCASTER
13. Birthplace MD.

MOTHER
14. Maiden name GENEVIEVE ~~SHEHART~~ Shuchart
15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 8 45 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland Md

19 Sept 8 19 45 Walter R. Brantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 5 19 45 at 5:50a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-3- 19 45 to 9-5- 19 45
and that I last saw h alive on 9-4- 19 45

Immediate cause of death Coronary Thrombosis
Due to Coronary Sclerosis
Due to
Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

DURATION
Since 8-3-45

Major findings of operations none
Date of op. none
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 9-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

CERTIFICATE OF DEATH

08637

Reg. Diat. No. 7

1. PLACE OF DEATH:

County: Allegany

City or town: Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 0 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Baston
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Alexander Lashbaugh

3. (b) Social Security Number: 213-10-5276

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Mal	White	Married

6.(b) Name of husband or wife: Fannie Lashbaugh

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): March 4, 1885

8. AGE:	Years	Months	Days	If less than one day
	60	5	29	hrs. min.

9. Birthplace: Baston, Allg. Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: C & N. Bus Co.

FATHER
12. Name: Benjamin Lashbaugh
13. Birthplace: Baston, Md.

MOTHER
14. Maiden name: Sarah Greenhowe
15. Birthplace: Baston, Md.

16. Informant: Mrs. Alexander Lashbaugh
Address: Baston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 6 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill

Location: Mascar Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Sept 6 19 45 S. A. Boucher
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3, 1945 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1945 to Sept. 3 1945 and that I last saw him alive on Sept 1 1945

Immediate cause of death	DURATION
Pernicious Anaemia	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other

Address: Lonaconing, Md. Date signed: Sept. 6 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91-C)

CERTIFICATE OF DEATH

Dr Gallens' 08638

★ Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Rafter 1 (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lucille Duncan Lemmert

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Lemmert 6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): January 16 1924

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
21	8	29		

9. Birthplace: Shaft, Allegany Cty., Md. (Town, county, and state)

10. Usual occupation: Laundress

11. Industry or business: Home

FATHER — 12. Name: Walter Duncan

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emma Meagher

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Wm. McGregor

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 18 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 9-19 1945 Mrs. Hadley N. Rice (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 1945 at 5 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to Sept. 15 1945 and that I last saw h[illegible] alive on Sept. 14 1945

Immediate cause of death	DURATION
Endocarditis	4 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. E. Gallens M.D. M. D. or other

Address: Frostburg, Md. Date signed: 9/17/45

Outside of City Limits

Cor. Room

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-7)

68639

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Near Cumberland Route 3

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred: Bowmans Addt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 3

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ~~Louis~~ Lewis Franklin Livingood

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Quilla F. Albright

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 3, 1871

8. AGE: Years	Months	Days	If less than one day
74	6	24	..... hrs. ..... min.

9. Birthplace Mayersdale, Pa (Town, county, and state)

10. Usual occupation Car repairman - retired

11. Industry or business Railroad

FATHER 12. Name [illegible]

FATHER 13. Birthplace [illegible]

MOTHER 14. Maiden name [illegible]

MOTHER 15. Birthplace [illegible]

16. Informant Walter E. Livingood

Address Route 3 Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1 1945 (month) (day) (year)

Cemetery or crematory Davis Memorial Cemetery

Location Oldtown Rd. Cumberland, Md.

18. Funeral director John J. Hoffman

Address Cumberland, Md.

19. Oct. 1, 1945 (Date rec'd by registrar) Wm. R. Trautman M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1945, at 7:10 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1945, to Sept 27 1945 and that I last saw him alive on Sept 24 1945

Immediate cause of death	DURATION
Organic Heart Disease	2 years
Due to Nephritis - Chronic	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos A Rowan M. D. or other

Address Cumberland Md Date signed 9/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-6)

CERTIFICATE OF DEATH

08640

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: Bedford

City or town: Buffalo Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Linda Mays

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 22, 1945

8. AGE: Years | Months: 2 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Curtis Mays
13. Birthplace: Penna.

MOTHER
14. Maiden name: Ethel Smith
15. Birthplace: Penna.

16. Informant: Curtis Mays
Address: Buffalo Mills RD #1 Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2, 45 (month) (day) (year)

Cemetery or crematory: Madley Cem

Location: Hyndman Penna.

18. Funeral director: Harvey A. Zengler

Address: Hyndman Penna.

19. Oct 1 1945 (Date rec'd by registrar) Witter R. Brantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30 1945 at 7:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28 1945, to September 30 1945

and that I last saw h... alive on September 24 1945

	DURATION
Immediate cause of death: peritonitis	2 days
Due to: Intussusception	3 days
Due to:	
Other conditions: Caecum & ileum tied in left lower abdomen	

(Include pregnancy within 3 months of death)

Major findings of operations: intussusception of ileum into caecum Date of op. 9-28-45

Autopsy results: gangrene of bowel part of ileum

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L Brings MD
M. D. or other

Address: Long Mdw Date signed 9-30-45

WITHIN CORPORATE LIMITS

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-2)

CERTIFICATE OF DEATH

08641

Reg. Diat. No. 4

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: West Virginia County: Mineral

City or town: Piedmont (If outside city or town limits, write RURAL and give nearest town)

Street No. 232 W. Fairview St. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: McNEMAR, WOODROW

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: SCHOPFERT, BETTY

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): JULY 22, 1918

8. AGE: Years: 27 Months: 1 Days: 11 If less than one day: hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: FIREMAN @ B. & O. RAILROAD

11. Industry or business:

FATHER — 12. Name: McNEMAR, DAVID A.

13. Birthplace: OHIO

MOTHER — 14. Maiden name: SHELL, STELLA

15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 6 - 1945 (month) (day) (year)

Cemetery or crematory: Fairview Cem

Location: Westernport, Md.

18. Funeral director: Emory Bolden

Address: Oakland, Md

19. Sept. 6, 1945 (Date rec'd by registrar) Walter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 1945 at 4:45 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 29 1945 to Sept 3 1945 and that I last saw him alive on Sept. 3 1945

Immediate cause of death: Lateral Sinus Thrombosis — DURATION: 1 day?

Due to: Meningitis (type undetermined) — 7 days?

Due to: Left Middle Ear abscess — 14 days?

Due to: and Left Mastoiditis — 14 days?

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stanley Jacobson M.D. or other

Address: 150 Baltimore St. Date signed: 9/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

08642

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Moscow, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Moscow, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Glenn Merrbaugh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3, 1931

8. AGE: Years 14 | Months 6 | Days 12 | If less than one day hrs. min.

9. Birthplace Frostburg - Allegany - Md (Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name William Merrbaugh

13. Birthplace not known

MOTHER 14. Maiden name Kathleen Lancaster

15. Birthplace Ridgely, W. Va

16. Informant Mrs. Mary Lancaster

Address Moscow, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18, 1945 (month) (day) (year)

Cemetery or crematory Laurel Hill

Location Moscow, Md.

18. Funeral director Ellsworth E. Boyd

Address Westernport, Md.

19. Sept 16 1945 (Date rec'd by registrar) S. D. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH about September 15th, 1945, at 8 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ?	DURATION
Fractured skull; Hemorrhage,	
(Comp., comminuted, fracture	unknown
Due to frontal bone)	
(~~A fall, striking head against~~	
Due to ~~rock~~)	
Accidental death by gunshot — a .22 caliber	
Other conditions bullet — U.S.A.	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op.

Autopsy results ~~no~~ Autopsy subsequent investigation.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 9-15-45

Where did injury occur? Near Moscow (City or town) Allegany (County) Maryland (State)

Injured at home, farm, industry, public place (where?) woods

Means of injury ~~fall (while~~ hunting ~~)~~ Injured at work? no

23. SIGNATURE Pierre H. Dorsey M.D.

M. D. or other

Address Cumberland, Maryland Date signed 9-16-45

08643

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (102)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 247 Henderson Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Anna Leona Merill

3.(b) Social Security Number 400

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Jesse Merill

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1906

8. AGE:

Years	Months	Days	If less than one day
38	11	29	..... hrs. ..... min.

9. Birthplace Hoffman Mines, Allegany Co, Md (Town, county, and state)

10. Usual occupation General Worker

11. Industry or business

FATHER 12. Name Philip Jenkins

13. Birthplace Frostburg Md.

MOTHER 14. Maiden name Mary Carter

15. Birthplace Vale Summit Md.

16. Informant Mrs Genevieve Lyons

Address Hoffman Mines Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2 1945 (month) (day) (year)

Cemetery or crematory St Michaels

Location Frostburg, Md.

16. Funeral director John D. Hafer

Address Cumberland Md.

19. 10-2 1945 Mrs. Hazley N. Rice

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945, at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Sept 1 1945 to Sept 29 1945 and that I last saw her alive on Sept 29 1945

Immediate cause of death	DURATION
Malignancy	
Due to Hypertension	6 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm McLane Jr M. D. or other

Address Frostburg Md Date signed 10-1-45

WITHIN CORPORATE LIMITS

DR. WILSON

08644

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-P)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County PRESTON
City or town TERRA ALTA
(If outside city or town limits, write RURAL and give nearest town)
Street No. ROUTE #4
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR. ARLEY S. MESSENGER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 1, 1903

8. AGE: Years	Months	Days	If less than one day
42	1	11	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation TRACKMAN - B. & O. RAILROAD
11. Industry or business
FATHER 12. Name GEORGE MESSENGER
13. Birthplace WEST VIRGINIA
MOTHER 14. Maiden name MARY CHAMBERS
15. Birthplace WEST VIRGINIA
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15 1945 (month) (day) (year)
Cemetery or crematory Terra alta Cem.
Location Terra alta W Va.
18. Funeral director Fike & Watson
Address Terra alta W Va.
19. Sept 17 1945 Winter R. Frantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH SEPTEMBER 12 1945 at 10:30 M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPTEMBER 11, 1945 to SEPTEMBER 12
and that I last saw him alive on Sept 12 1945
Immediate cause of death Shock following operation for obstruction of Intestines — DURATION 1 Day
Due to
Due to
Other conditions Diabetes Mellitus — 7
(Include pregnancy within 3 months of death)
Major findings of operations Volvulus, Hemorrhage & small intestine Date of op. 9-12-45
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE F. M. Wilson M.D. M. D. or other
Address Cumberland Md Date signed 9-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160)

CERTIFICATE OF DEATH

★ 08645

Reg. Diat. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

114 Maple Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 Maple St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby Michael

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1945 6:20 P.M.

8. AGE: Years | Months | Days | If less than one day: hrs. 10 min.

9. Birthplace Frostburg, Allegany, Maryland (town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Edgar Cecil Michael

FATHER 13. Birthplace Westernport, Md

MOTHER 14. Maiden name Edna Elizabeth Lahew

MOTHER 15. Birthplace Lander, Md.

16. Informant Mrs. Edgar Cecil Michael

Address 114 Maple St - Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/13-1945 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md

18. Funeral director Jacob A. Zeller

Address Frostburg Md.

19. 9-13 1945 Mrs. Nancy N. Rice Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1945 1945, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 12 1945 to 1945 and that I last saw h alive on 1945

Immediate cause of death	DURATION
Respiratory Paralysis	10 min
Due to Infl. Cranial Hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W D McCandlish M.D. M. D. or other

Address Frostburg Md Date signed Sept 12 1945

WITHIN CORPORATE LIMITS

08646

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 weeks

Hospital, institution, or street address where death occurred: 705 Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Ricardy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Mary Catherine Miller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George Miller

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): April 3, 1887

8. AGE: Years	Months	Days	If less than one day
58	5	17	..... hrs. ..... min.

9. Birthplace: Paw Paw, Morgan Co. W. Va (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER 12. Name: Edward McAtee

13. Birthplace: W. Va

MOTHER 14. Maiden name: Hattie Gross

15. Birthplace: Pa.

16. Informant: George Miller

Address: RFD 1 - Box 138, Paw Paw W. Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 23, 1945 (month) (day) (year)

Cemetery or crematory: Miller Cemetery

Location: Ricardy, Md

18. Funeral director: John J. Haley

Address: Cumberland Md

19. Sept 22, 1945 (Date rec'd by registrar) Walter R. Beanty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 1945 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 18 1945 to Sept 20 1945

and that I last saw h... alive on Sept 20 1945

Immediate cause of death	DURATION
Carcinomata	2 mo.
Due to Metastases	
Due to Carcinoma of stomach	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. K. Owens M.D. M. D. or other

Address: 133 Va Ave Date signed 9/22/45

DR. HODGES

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08647

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rear 123 Roberts Pl
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SANDRA KAY MOFFITT

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE (INFANT)

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JUNE 18 1945

8. AGE: ~~Years~~ ~~Months~~ ~~Days~~ If less than one day
3 MONTHS 18 days. hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: JAMES MOFFITT
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: VIRGINIA SHANHOLTZ
15. Birthplace: MARYLAND

16. Informant: MRS. JAMES E. MOFFITT
Address: REAR 123 ROBERTS PLACE CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2 1945 (month) (day) (year)
Cemetery or crematory: Hillcrest Lawn
Location: Cumberland, Md
18. Funeral director: Louis Stein Sons
Address: Cumberland, Md

19. Oct. 2, 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION 11;05

20. DATE OF DEATH: SEPTEMBER 30, 1945 at P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30 19 45 to Sept 30 19 45
and that I last saw her alive on Sept. 30 19 45

Immediate cause of death	DURATION
Debilitation	
Malnutrition	
Due to	
Due to	
Other conditions: Prematurity	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W C Hodges M. D. or other
Address: Cumberland, Md Date signed: 9/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Dr Dickl

08648

★ Reg. Diat. No. 9

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 12 Uhl Street

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Uhl Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward Lee Nickel

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 7, 1925

8. AGE: Years	Months	Days	If less than one day
20	3	28	..... hrs. ..... min.

9. Birthplace Frostburg
(Town, county, and state)

10. Usual occupation unbalid

11. Industry or business

FATHER
12. Name Cyril Nickel
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Wikbrecht
15. Birthplace Maryland

18. Informant Mrs. Mary Nickel
Address Frostburg, Md.

17. Burial Date thereof Sept. 8 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg Md.

18. Funeral director J. J. Dudt
Address Frostburg Md.

19. 9-7 1945 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1945 at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24 1945 to Sept 5TH 1945 and that I last saw him alive on September 4 1945

Immediate cause of death	DURATION
Broncho - Pneumonia.	1 wk.
Due to Hypertrophic Muscular	
Due to Dystrophy	14 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Dickl, M.D.
M. D. or other

Address Frostburg, Md. Date signed 9/7/45

WITHIN CORPORATE LIMITS

08649

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, Institution, or street address where death occurred: 4 N. Oldtown Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 N. Oldtown Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas F. Noel

3. (b) Social Security Number 220-07-6817

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Canning

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): — 1905

8. AGE: Years	Months	Days	If less than one day
40	—		..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Tri State Roofing Co.

FATHER — 12. Name: Noel

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Sarah E Lease

MOTHER — 15. Birthplace: W. Va.

16. Informant: Ida Brand

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15 45 (month) (day) (year)

Cemetery or crematory: Lease's Run

Location: Frostburg Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Sept. 15, 1945 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 19 45 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11 19 44, to Sept 13 19 45

and that I last saw him alive on Sept 13 19 45

Immediate cause of death: Chronic Valvular Heart Disease — DURATION: 20 yrs.

Due to: Decompensation — 2 days

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. Blackburn M. D. or other

Address: 133 Va Ave Date signed: Sept 13 45

WITHIN CORPORATE LIMITS

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

08650

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 YRS.
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 74 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 PARK ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MR JOSEPH E. O'ROURKE

3.(b) Social Security Number: 217-10-7798

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: ESTHER TIERNEY.
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): APRIL 19 1908

8. AGE: Years	Months	Days	If less than one day
37	4	13	...hrs. ...min.

9. Birthplace: MIDLAND MD.
(Town, county, and state)

10. Usual occupation: ~~NONE~~ Salesman

11. Industry or business:

FATHER
12. Name: JOHN O'ROURKE
13. Birthplace: MD.

MOTHER
14. Maiden name: MARY CREAMER
15. Birthplace: MD.

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4 1945 (month) (day) (year)
Cemetery or crematory: St Pat Cem.
Location: Cumberland md
18. Funeral director: Louis Stein Inc
Address: Cumberland md

19. Sept 3 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT. 2 1945 at 12:40 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1945 to Sept 2 1945 and that I last saw h.. alive on Sept 1 1945

Immediate cause of death	DURATION
Acute Hepatitis	about 6 wks
Due to	
Due to	
Other conditions Lobar Pneumonia (Rt. upper Lobe) (Include pregnancy within 3 months of death)	

Major findings of operations: None
Date of op.: None
Autopsy results: Liver Changes from acute
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 9-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Burnett

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

08651

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, Institution, or street address where death occurred: Allegany Hospital, Cumberland Md

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 936 Gay St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3. (a) FULL NAME: Adam Oster

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Alverta Oster

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): August 12th, 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	0	19		

9. Birthplace: Beans Cove, Pa (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Salomon Oster

13. Birthplace: Pa

MOTHER — 14. Maiden name: ?

15. Birthplace:

16. Informant: Joseph C. Wilson

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4, 1945 (month) (day) (year)

Cemetery or crematory: Beans Cove Methodist

Location: Beans Cove, Pa.

18. Funeral director: John F. Hofer

Address: Cumberland, Md.

19. Sept. 4, 1945 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/1 1945 at 1:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20. 1945 to Sept. 1, 1945

and that I last saw him alive on Sept. 1, 1945

	DURATION
Immediate cause of death: Generalized Arteriosclerosis	5 yrs.
Due to: Gangrene Right Foot	2 wks.
Due to: Anaemia	10 days
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) ——— (County) ——— (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work?

23. SIGNATURE: Alan R. Burnett M. D. or other

Address: Cumberland, Md. Date signed: Sept. 3, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

M

08652

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30?)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland [redacted]

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? –

Hospital, Institution, or street address where death occurred: Sylvan Retreat

How long in hospital or Institution? yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Howard St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Florence Poole

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): June 4 1896

8. AGE: Years	Months	Days	If less than one day
49	3	6	... hrs. ... min.

9. Birthplace: Oldtown Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Samuel Poole

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Rosie Piper

MOTHER — 15. Birthplace: Md.

16. Informant: John J Poole

Address: Rider R.D. Cumb'd Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12 45 (mooth) (day) (year)

Cemetery or crematory: Oldtown Cem.

Location: Oldtown Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Sept 13 19 45 (Date rec'd by registrary) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 10 19 45, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 34 to 9-10-45 19 45

and that I last saw h... alive on 9-8-45 19 45

	DURATION
Immediate cause of death: Lung Phthisis	Few Months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 mooths of death)

Major findings of operations: None Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 9-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

Jacobson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

08653

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland ~~(Rural) Route 1~~
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 9 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Near Cumberland, (Locust Grove)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Myrtle Mary "Ross" Porter

3. (b) Social Security Number: 217-10-6762

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Glison T. Porter

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): May 2, 1903

8. AGE:	Years	Months	Days	If less than one day
	42	4	5	...hrs. ...min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER — 12. Name: Floyd Kline

FATHER — 13. Birthplace: Norfolk, Va.

MOTHER — 14. Maiden name: Rebecca Thompson

MOTHER — 15. Birthplace: Connellsville, Pa.

16. Informant: Glison T. Porter

Address: Route 1, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10 1945 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart, Maryland

18. Funeral director: John J. Hoban

Address: Cumberland, Md.

19. Sept. 10, 1945 (Date rec'd by registrar) Winter R. Rantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7 1945, at 2:12 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1945 to Sept 7 1945 and that I last saw h... alive on Sept 6 1945

Immediate cause of death	DURATION
a. Uremia	3 wks.
Due to: Hypertensive Cardio-vascular Renal disease	?
Due to:	
Other conditions: Chronic Nephritis	?
Thrombophlebitis	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel Jacobson M. D. or other

Address: 15 S. Liberty St. Date signed 9/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

08654

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs - Some - 13 days.
Hospital, Institution, or street address where death occurred: Douglas Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Douglas Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Ralston

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Nora Hilleban Ralston
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1900

8. AGE:

Years	Months	Days	If less than one day
45	6	13	hrs. min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Coal Miner (Retired)
11. Industry or business: Maryland Coal Co.
FATHER 12. Name: Henry Ralston
13. Birthplace: Lonaconing, Md.
MOTHER 14. Maiden name: Margaret Barclay
15. Birthplace: Lonaconing, Md.
16. Informant: Mrs. Thad Kitt Clair
Address: New York, N. Y.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. Sept. 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13th 1945 at 11 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11 1945, to Sept. 13 1945
and that I last saw him alive on Sept. 13th 1945

Immediate cause of death	DURATION
cerebral Hemorrhage	
Due to	
Due to	
Other conditions: Lues, Insanity	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: Sept. 15, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Johnson

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (DHE)

CERTIFICATE OF DEATH

08655

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany County

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. # 2, Humble Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Hugh Walter Robey

3.(b) Social Security Number 212-18-1742

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie M. Robey

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): May 23, 1889

8. AGE: Years 56 | Months 3 | Days 25 | If less than one day: ...hrs. ...min.

9. Birthplace: Md. Hancock, Md
(Town, county, and state)

10. Usual occupation: Engineering Dept

11. Industry or business: Celanese

FATHER
12. Name: John Robey
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Souders
15. Birthplace: Md.

16. Informant: Homer E. Robey

Address: Rt. 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: 6 miles west of Hancock on Route 40

18. Funeral director: John L. Hofer

Address: Cumberland, Md.

19. Sept 19 19 45 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 19 45 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 23 19 45 to September 18 19 45

and that I last saw him alive on September 17 19 45

	DURATION
Immediate cause of death: Carbuncle of face	3 wks
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Z. Johnson Jr. M.D.

M. D. or other

Address: Cumberland, Md. Date signed: 9-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-B)

CERTIFICATE OF DEATH

08656

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt Savage (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Victor Robison

3. (b) Social Security Number: 219-14-6575

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Ruth Tighe

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13th, 1894

8. AGE: Years	Months	Days	If less than one day
51	5	7	hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: General Farming

FATHER — 12. Name: Wm Robison

FATHER — 13. Birthplace: Garrett County, Md.

MOTHER — 14. Maiden name: Fannie Blocher

MOTHER — 15. Birthplace: Garrett County, Md.

16. Informant: Mrs Victor Robison

Address: Mt Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24, 1945 (month) (day) (year)

Cemetery or crematory: St Michaels Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. Sept 22, 1945 (Date rec'd by registrar) Walter R. Trautman M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/20/45 at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-2-, 1945, to 9-20, 1945, and that I last saw h alive on 9-19-, 1945.

	DURATION
Immediate cause of death: uremia	One week
Due to: chronic nephritis	10 yrs
(glomerulo-nephritis)	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L Brin MD (M. D. or other)

Address: Lonaconing Md Date signed: 9-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (60-a)

08657

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital.
How long in hospital or institution? 1 hr. 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna. County Bedford
City or town Rt 4 Bedford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Baby Boy Schaeffer.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1945

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 35 min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Gerald Schaeffer
13. Birthplace Pennsylvania

MOTHER
14. Maiden name MARIE Price
15. Birthplace Pennsylvania

16. Informant Gerald Schaeffer
Address Rt 4 Bedford Penna

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 30 1945 (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Rainsburg, Penna

18. Funeral director Lathe
Address Near Bedford, Penna

19. Sept. 29 1945 (Date rec'd by registrar) Hunter R. Drake M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/45 19..... at 1-30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/28/45 19..., to 9/29 19 45 and that I last saw him alive on 9-29/45 19.....

Immediate cause of death	DURATION
Central Hemorrage	
Due to Face presentation prolonged Labor	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE. O Kesler M. D. or other
Address 122 Bedford St Date signed 9/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

DR. HAWKINS

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-R)

08658

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 DAYS
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County MINERAL
City or town PIEDMONT W.VA.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 JONES ST.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME MR LORY E SEE

3. (b) Social Security Number 216-07-2349

4. Sex MALE
5. Color or race WHITE
6.(a) Single, married, widowed, or divorced MARRIED
6.(b) Name of husband or wife ELTA FUNKHOUSER
6.(c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) JAN. 12, 1897
8. AGE: Years 48 Months 8 Days 15 If less than one day ...... hrs. ...... min.
9. Birthplace W.VA
(Town, county, and state)
10. Usual occupation W.VA PULP & PAPER CO.
11. Industry or business Painter
FATHER 12. Name SIMMOR SEE
13. Birthplace W.Va
MOTHER 14. Maiden name MARY LANTZ
15. Birthplace W.Va.
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD
17. Burial Date thereof Sept 30-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Philos Cemetery
Location Westernport. Md
18. Funeral director W.H. Fredlock
Address Piedmont W. Va.
19. Sept. 27, 1945 Walter R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 27 1945, at 5:25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 17, 1945 to Sept. 27, 1945
and that I last saw him alive on Sept. 26, 1945
Immediate cause of death Extensive late Retroperitoneal Carcinoma, with greatly enlarged
Due to & metastatic Carcinoma
Due to of liver - Thymus
Other conditions Retroperitoneal small Pairut. Ideal explorations
(Include pregnancy within 3 months of death)
Major findings of operations of abd showed above
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
DURATION

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ...... Date of ......
Where did injury occur? ...... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ......
Means of injury ...... Injured at work? ......

23. SIGNATURE A H Hawkins M. D. or other
Address ...... Date signed ......

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2)

CERTIFICATE OF DEATH

08659

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or Town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 mo.

Hospital, institution, or street address where death occurred: 640 Bedford St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 640 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War.

3.(a) FULL NAME: John Loran Shaffer.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eloise Wilson

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Jan 20 1889

8. AGE:

Years	Months	Days	If less than one day
56	8	9	...hrs. ...min.

9. Birthplace: St George W. Va.
(Town, county, and state)

10. Usual occupation: grocer (Retired)

11. Industry or business

FATHER

12. Name: John Adam Shaffer

13. Birthplace: Preston Co. W. Va.

MOTHER

14. Maiden name: Anna Sophia Roth

15. Birthplace: Garrett Co. Md

16. Informant: Mrs. Eloise W. Shaffer.

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 1 '45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Oct. 1, 19 45 Walter R. Frantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29, 1945, at 3 o'clock P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 1944 to Sept. 29, 1945 and that I last saw h... alive on Sept. 25, 1945

Immediate cause of death: Chronic Myocardial Degeneration — Duration: Since Sept 1944

Due to: Hypertension — Duration: Since Sept 1944

Due to: ...

Other conditions: ...

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

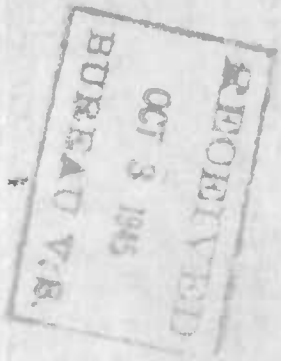
Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 9-29-45

Dr Williams



WITHIN CORPORATE LIMITS

DATE Topper

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-c)

CERTIFICATE OF DEATH

08660

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County Bedford
City or town Hyndman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME
Mr. William Shroyer

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8.(b) Name of husband or wife Clara Burley
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	17	..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Abraham Shroyer
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Elaine? Wolford
15. Birthplace Pennsylvania

16. Informant Memorial Hospital
Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 21, 1945 (month) (day) (year)
Cemetery or crematory Hyndman
Location Hyndman
18. Funeral director Harvey F. Feagley
Address Hyndman, Pa.

19. Sept 20, 19 45 (Date rec'd by registrar) Winter R. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 19 45 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Carcinoma of Descending Colon	4 mos.
Due to	
Due to	
Other conditions	?

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John A. Topper M. D. or other
Address Hyndman Pa. Date signed 9-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98d)

CERTIFICATE OF DEATH

Cert file 08661

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 DAYS

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PA County SOMERSET

City or town BERLIN PA.
(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD #3
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME MR NORMAN B. SNYDER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ANNIE WAHL

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) APRIL 12, 1869

8. AGE: Years	Months	Days	If less than one day
76	5	14	..... hrs. ..... min.

9. Birthplace PA (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name LEVI SNYDER

13. Birthplace PA.

MOTHER 14. Maiden name SUSAN RINGER

15. Birthplace PA. SUSAN RINGER

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 1945 (month) (day) (year)

Cemetery or crematory Berlin Pa

Location Berlin Pa

18. Funeral director Johnson Funeral Home

Address Berlin Pa

19. Sept 27 1945 (Date rec'd by registrar) Wm. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 26 1945 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9.20. 1945 to 9.26. 1945 and that I last saw him alive on 9.26. 1945

Immediate cause of death	DURATION
Chronic Cholecystitis	
Due to Myocardial Degeneration	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D.

Address Cumberland Date signed 9-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Hodges

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-c)

CERTIFICATE OF DEATH

08662

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hours 50 minutes
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 12 hours 50 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Flintstone (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Baby Girl Sowers

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 1, 1945

8. AGE: Years | Months | Days | If less than one day: 12 hrs. 50 min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: New born

11. Industry or business

FATHER — 12. Name: Herman Sowers
FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Genevieve Stotler
MOTHER — 15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Mt Hope Cem (Burial, cremation, or removal. Which?) Date thereof Sept 2 1945 (month) (day) (year)
Cemetery or crematory: Mt Hope Cem
Location: Bedford Co. Pa.

18. Funeral director: Louis Stein Sons
Address: Cumberland Md

19. Sept. 2, 1945 (Date rec'd by registrar) Wintes L. Grant M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1945 at 6:50 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 1945 to Sept. 1 1945 and that I last saw h. l. w. alive on Sept. 1 1945

Immediate cause of death: atrophic Cirrhosis of Liver. — DURATION: 2 wks.

Due to:

Due to:

Other conditions: Right otitis Media pneumonia. — June 19

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results: atrophic cirrhosis - acutes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W.F. Williams (For W.R. Hodges) M. D. or other
Address: Cumberland, Md Date signed: 9/2/45

DR. JACOBSON

WITHIN CORPORATE LIMITS

08663

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: WESTERNPORT
(If outside city or town limits, write RURAL and give nearest town)
Street No. 268 MAIN STREET EXTENDED
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SPURLING, JOHN W. MR.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: GREENWADE, CARRIE
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): 10/18/1867

8. AGE: Years	Months	Days	If less than one day
77	10	26	hrs. min.

9. Birthplace: W.VA. (Town, county, and state)
10. Usual occupation: NONE
11. Industry or business

FATHER
12. Name: SPURLING, JESSE
13. Birthplace: W.VA.

MOTHER
14. Maiden name: WHITE, MARY ANN
15. Birthplace: W.VA.

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17 1945 (month) (day) (year)
Cemetery or crematory: Philos Cemetery
Location: Westernport Md
18. Funeral director: E. Clarence Miller
Address: Westernport Md

19. Sept. 15, 1945 (Date rec'd by registrar) Winter R. Brantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 14 1945 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPTEMBER 13 1945, to Sept 14 1945
and that I last saw h[illegible] alive on Sept 14 1945

Immediate cause of death	DURATION
Uremia	?
Due to: Pernicious Anemia	?
Due to:	
Other conditions: Cataracts both Eyes	—

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James Jacobson M.D.
M. D. or other
Address: U.S. Veterans Hosp Date signed 9/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Outside of City Limits

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08664

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Route 3 Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or Street address where death occurred Bedford Rd., Rt. # 3.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bedford Rd., Rt. # 3.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Harriett Jewell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Wm H. Jewell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 19, 1863

8. AGE: Years 82 | Months 3 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Piney Creek Bedford Co, Pa
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER 12. Name Elijah Shipley

13. Birthplace Piney Creek Pa.

MOTHER 14. Maiden name Nancy Martin

15. Birthplace Clarville Pa

16. Informant Lester Jewell

Address Route 3, Cumberland, Md

17. Burial Date thereof Sept 23, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Zion Christian Cemetery

Location Shawsville, Pa

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept. 22 1945 Winter R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1945 at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 1945, to Sept. 21, 1945 and that I last saw her alive on Sept. 21, 1945

Immediate cause of death Angina Pectoris — DURATION 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE J. A. Watson M. D. or other

Address Little Orleans, Md Date signed Sept. 21, 1945

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-2)

08665

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 minutes
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 529 Pine Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Baby Girl Melodie Ann Thomas

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9/17/45

8. AGE: Years | Months | Days | If less than one day: hrs. 20 min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER
12. Name: Charles Edward Thomas
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Betty Catherine Golden
15. Birthplace: Cumberland Md.

16. Informant: Charles E. Thomas
Address: 529 Pine Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 19, 1945 (month) (day) (year)

Cemetery or crematory: Trinity Lutheran
Location: Cumberland, Md

18. Funeral director: John J. Hooper
Address: Cumberland Md

19. Sept 19 1945 (Date rec'd by registrar) Victor L. Grant M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/17 1945 at 5:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Status Thymicus	
Asphyxiation	
Due to: Due to Compression	
of cord, funny around	
Due to: neck twisted	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ✓ (City or town) ✓ (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: D Kesler M. D. or other
Address: 142 Bedford St. Date signed: 9/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS
DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08666

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 HOUR

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. ROUTE #5
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BABY ROBERT WM. VAN'METER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) SEPT. 21, 1944

8. AGE: Years	Months	Days	If less than one day
	11	24	hrs. ... min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name RAYMOND VAN'METER
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name VIRGINIA LEASE
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 21, 1945 (month) (day) (year)
Cemetery or crematory Pleasant Dale Cem
Location Pleasant Dale W. Va.
18. Funeral director Louis Stein, Inc
Address Cumberland, Md.
19. Sept. 19 19 45 (Date rec'd by registrar) Wintes R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 18, 1945 8:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18 19 45 to Sept. 18, 45 and that I last saw h... alive on Sept. 18 19 45

	DURATION
Immediate cause of death: Status Lymphaticus	
Due to: Fall From Crib, Radius & Ulna Fracture by Convulsion	Sept. 18
Due to: 8 hours later.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Very large thymus gland.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W R Hodges, M.D.
M. D. or other
Address ... Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. ELIASON

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-P)

CERTIFICATE OF DEATH

08667

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 DAYS
Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town LOO ST. FROSTBERG, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. LOO ST
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME WAGNER, LOUISE MISS

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCTOBER 22, 1860

8. AGE: Years	Months	Days	If less than one day
84	10	9	..... hrs. ..... min.

9. Birthplace MD. Grantsville, Garrett Co. (Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER 12. Name HENRY WAGNER
13. Birthplace Germany

MOTHER 14. Maiden name Margaretha Wagner
15. Birthplace Germany

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3-1945 (Month) (day) (year)
Cemetery or crematory allegany
Location Frostburg

18. Funeral director J. F. Hurst
Address Frostburg

19. Sept 2 19 45 Wm. R. Trautz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 1 19 45 at 5:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 25 19 45 to Sept 1 19 45
and that I last saw h alive on Aug. 31 19 45

Immediate cause of death	DURATION
Cerebral Thrombosis	2 wks
Due to Arteriosclerosis.	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. L. Clemons M. D. or other
Address Retired Cumberland Md. Date signed 9/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08668

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 years

Hospital, Institution, or street address where death occurred: St. Marys Ver. Ins

How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No. St. Marys Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war 2

3. (a) FULL NAME Amanda King Walters

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William Walters

6.(c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) June 13, 1871

8. AGE:

Years	Months	Days	If less than one day
74	3	16	...hrs. ...min.

9. Birthplace Perry, Ohio (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

FATHER
12. Name King
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mr. Charles Walters
Address Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 2, 1945 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing Md

18. Funeral director Mr. Eichelberger

Address Lonaconing, Md

19. Sept. 24 1945 D. E. Oakley Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1945, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29 1945, to Sept. 29 1945 and that I last saw her alive on Sept. 29 1945

Immediate cause of death	DURATION
Angina Pectoris	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE J. Henry M. Hodgson M.D. M. D. or other

Address Lonaconing Md. Date signed Oct 2nd 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

(8669)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60. Years

Hospital, Institution, or street address where death occurred:

132 Utah Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 132. Utah Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Reed Whitman

3.(b) Social Security Number: 217-10-7766

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith Whitman

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): October 17 1884

8. AGE: Years	Months	Days	If less than one day
60	11	5	....hrs. ....min.

9. Birthplace: Cumberland, Allegany Co., Maryland (Town, county, and state)

10. Usual occupation: Contractor

11. Industry or business: Building Houses

FATHER — 12. Name: Henry Whitman

13. Birthplace: Germany

MOTHER — 14. Maiden name: Elizabeth Huff

15. Birthplace: England

16. Informant: Mrs. James R. Whitman

Address: 132. Utah Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/25/45 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md.

18. Funeral director: Willian H. Kight

Address: Cumberland, Md.

19. Sept. 24, 19 45 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 22 1945, at 6-30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1942, to September 22 1945 and that I last saw h... alive on September 17 1945

	DURATION
Immediate cause of death: congestive heart failure	1 Year
Due to: Chronic myocarditis	3 Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. Morris M.D. M. D. or other

Address: Long Mod Date signed: 9-24-45

Outside of City Limits

08670

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yrs.
Hospital, institution, or street address where death occurred: Barrows Park Rt 40 W
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Cumberland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Barrows Park.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nellie S. Wickard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 27 1861

8. AGE: Years 83 | Months 8 | Days 19 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Housekeeper (Retired)

11. Industry or business: Hotel

FATHER
12. Name: Levi Wickard.
13. Birthplace: Md.

MOTHER
14. Maiden name: Amanda Boogher.
15. Birthplace: Md.

16. Informant: Mrs Chas Otto.
Address: Barrows Park.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 13 '45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland

18. Funeral director: Louis Stein Sons
Address: Cumberland

19. Sept. 13 1945 Walter R. Beantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9 1945 to Sept. 11 1945 and that I last saw h alive on Sept. 9 1945

Immediate cause of death: Chronic Myocarditis	DURATION
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W P Hodges, M. D.
M. D. or other
Address: Cumberland Md. Date signed: 9/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

Trevaskis

08671

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, Institution, or street address where death occurred:

428 Forester Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Near Athemas Pa.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Dennis Wigfield

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Matilda Shipley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1862

8. AGE:

Years	Months	Days	If less than one day
83	0	24	..... hrs. ..... min.

9. Birthplace Bedford County, Pa

(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business General Farming

FATHER 12. Name Wm Wigfield

FATHER 13. Birthplace Bedford Co. Pa.

MOTHER 14. Maiden name Nancy Pennell

MOTHER 15. Birthplace Bedford Co. Pa.

16. Informant Mrs Bernie Whitman

Address 428 Forester Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9, 1945 (month) (day) (year)

Cemetery or crematory Fairview Christian Cemetery

Location Dugleswith, Pa.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept. 9 19 45 Witness R. Trevaskis M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945, to Sept 6 1945 and that I last saw him alive on Sept 6 1945

Immediate cause of death	DURATION
Chronic myocarditis	3 yrs.
Due to —	
Due to	
Other conditions Arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. F. Trevaskis, M.D.

M. D. or other

Address Cumberland Md Date signed Sept 8-'45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08672

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Allegheny Cty.

City or town: E. Pittsburgh Pa.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 408 Cline St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Williams

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Richard Williams

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Jan 8 — 1889

8. AGE:

Years	Months	Days	If less than one day
56	7	27	hrs. min.

9. Birthplace: Frostburg - alleg - md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: David Lewis

13. Birthplace: Frostburg, md.

MOTHER — 14. Maiden name: Rhoda Crosby

15. Birthplace: Pa.

18. Informant: Richard Williams

Address: E. Pittsburgh, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-7-45 (month) (day) (year)

Cemetery or ~~crematory~~: Woodlawn

Location: Williamsburg, Pa

18. Funeral director: J. J. Durst

Address: Frostburg Md

19. 9-5 (Date rec'd by registrar) 19 45 Mrs. Addley A. Poe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4 19 45, at 8:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14 19 45, to September 4 19 45

and that I last saw h. s. alive on 9/4 19 45

Immediate cause of death	DURATION
Acute cardiac failure	1 hour
Due to: Thyroidectomy	
Due to: Toxic adenoma to Thyroid	15 yrs
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Degenerating adenomata Thyroid Date of op. 9/4/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hilda Jane Walters M.D. M. D. or other

Address: Frostburg, Md. Date signed 9/4/45

WITHIN CORPORATE LIMITS

(M)

Dr Hodges

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a)

CERTIFICATE OF DEATH

11873

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

221 Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 Bedford

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eva Cecilia Willingham

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

B.(b) Name of husband or wife Chas A Willingham

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1882

8. AGE: Years 63 Months 7 Days 14 If less than one day ..... hrs. ..... min.

9. Birthplace Harpers Ferry W Va

(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business At Home

FATHER 12. Name John Phillip Trail

13. Birthplace Harpers Ferry W.Va.

MOTHER 14. Maiden name Mary Rodrick

15. Birthplace Harpers Ferry W.Va.

16. Informant Mrs. Lillian Miller

Address 221 Bedford St. Cumberland Md

17. Burial Date thereof Sept 9, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest

Location Cumberland Md

18. Funeral director Wm. J. Right

Address Cumberland Md.

19. Sept 8, 1945 Winter R. Trout M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945 at 1040 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1943 to Sept 6 1945

and that I last saw her alive on Sept 5 1945

Immediate cause of death	DURATION
Carcinoma of Cervix Uteri	1 yr 3 mo
Due to Uremia from ureteral obstruction.	5 days
Due to	
Other conditions Recto-vaginal fistula	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE U R Hodges M.D.

Address Cumberland Md. M. D. or other

Date signed 9/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15